CHAPTER 50-24.1
MEDICAL ASSISTANCE FOR NEEDY PERSONS

50-24.1-01. Purpose. The purpose of this chapter is to provide medical care and services to persons whose income and resources are insufficient to meet such costs, and further to provide preventive, rehabilitative, and other services to help families and individuals to retain or attain capability for independence or self-care.

50-24.1-01.1. Department to submit plans and seek waivers. The department of human services may submit state plans in forms that are consistent with and which meet requirements for such plans which are or may be imposed under the Medicare Catastrophic Coverage Act of 1988 [Pub. L. 100-360; 102 Stat. 729; 42 U.S.C. 1396a, et seq., as amended]. The department may take such actions as are reasonably necessary to conform the administration of programs under its supervision and direction to the requirements of the Medicare Catastrophic Coverage Act of 1988 and the state plans submitted thereunder, including the issuance of policy manuals, forms, and program directives. The department may seek appropriate waivers of the requirements of the federal statutes or regulations as authorized by federal law.

50-24.1-01.2. Department may establish and administer state unified dental insurance coverage plan. The department of human services may establish a state unified dental insurance coverage plan to provide dental service coverage to all persons eligible for medical assistance pursuant to section 50-24.1-02. The department, or a private entity under contract with the department, may administer the plan. Any private entity that contracts with the department under this section must have on its board of directors at least one dentist and one person to whom services are provided under the plan. The plan must provide insurance coverage of the general and usual services rendered and the care administered by licensed dentists. The department may apply for federal funds to administer the plan based on estimates of the medical assistance-eligible persons within this state. The department may apply for a waiver to allow the use of medicaid funds to administer the plan and to provide the services determined by the department.

50-24.1-01.3. Department to comply with federal requirements - Interagency cooperation - Civil money penalty fund.

1. The department of human services shall take any action necessary to comply with the requirements of section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)], including establishing a process to enforce compliance by nursing facilities with requirements for participation in the medical assistance program that conforms to any federal regulations implementing that section.

2. The state department of health and the department of human services shall cooperate to achieve prompt and effective implementation of subsection 1.

3. The state treasurer shall establish a fund for the receipt of any civil money penalties imposed under subsection 1. Any civil money penalty paid to the department of human services under subsection 1 must be deposited in that fund and, subject to the limits of legislative appropriation, may be expended for the sole purpose of the protection of the health or property of residents of nursing facilities that the state or federal government finds deficient.

4. This section may not be construed to create any right or authorize any activity not provided for in section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)] or its implementing federal regulations.

5. Before the establishment and assessment of civil money penalties permitted by section 1919(h) of the federal Social Security Act [42 U.S.C. 1396r(h)], the

department of human services is encouraged to submit a plan of alternative remedies in accordance with section 1919(h)(2)(B)(ii) of that Act.

50-24.1-02. Eligibility. Within the limits of legislative appropriations, medical assistance may be paid for any person who either has income and resources insufficient to meet the costs of necessary medical care and services or is eligible for or receiving financial assistance under chapter 50-09 or title XVI of the Social Security Act, as amended, and:

1. Has not at any time before or after making application for medical assistance made an assignment or transfer of property for the purpose of rendering that person eligible for assistance under this chapter. For the purposes of making any determination or redetermination of eligibility, the phrase "assignment or transfer" includes actions or failures to act which effect a renunciation or disclaimer of any interest which the applicant or recipient might otherwise assert or have asserted, or which serve to reduce the amounts which an applicant or recipient might otherwise claim from a decedent's estate, a trust or similar device, or a person obligated by law to furnish support to the applicant or recipient.

2. Has applied or agrees to apply all proceeds received or receivable by that person or that person's eligible spouse from automobile accident medical benefits coverage and private health care coverage to the costs of medical care for that person and that person's eligible spouse and children. The department of human services may require from any applicant or recipient of medical assistance the assignment of any rights accruing under automobile medical benefits coverage or private health care coverage. Any rights or amounts so assigned must be applied against the cost of medical care paid on behalf of the recipient under this chapter. The assignment is not effective as to any carrier before the receipt of notice of assignment by such carrier.

3. Is eligible under rules and regulations established by the department of human services.

50-24.1-02.1. Assignment of claim. Each applicant or recipient of benefits under this chapter must be deemed to have assigned, to the department of human services, any right of recovery the applicant or recipient may have for medical costs incurred under this chapter not exceeding the amount of funds expended by the department for the care and treatment of the applicant or recipient. The applicant or recipient, or other person empowered by law to act in the applicant's or recipient's behalf, shall execute and deliver an assignment of claim, assignment of rights, or other authorizations as necessary to secure fully the right of recovery of the department. The assignment:

1. Is effective as to both current and accrued medical support recovery obligations.

2. Takes effect upon a determination that an applicant is eligible for assistance under this chapter.

50-24.1-02.2. Community spouse resource allowance. In determining eligibility for medical assistance applicants and recipients, the department of human services shall establish a community spouse resource allowance equal to the maximum community spouse resource allowance as provided by 42 U.S.C. 1396r-5(f)(2). This section applies to a community spouse of an institutionalized spouse. For purposes of this section, "institutionalized spouse" includes an individual who is described in 42 U.S.C. 1396a(a)(10)(A)(ii)(VI).

50-24.1-02.3. When designated pre-need funeral service contracts, prepayments, or deposits not to be considered in eligibility determination. In determining eligibility for medical assistance, the department of human services may not consider as an available resource any pre-need funeral service contracts, prepayments, or deposits to a fund which total five thousand dollars or less designated by the applicant or recipient as set-aside to pay for the applicant's or recipient's funeral. An applicant or recipient designates a prepayment or deposit

for that applicant's or recipient's burial by providing funds that are to be used for the funeral or burial expenses of the applicant or recipient. In addition, the applicant or recipient may designate all or a portion of the three thousand dollar asset limitation for funeral pre-need contracts, prepayments, or deposits. Interest or earnings retained in a funeral fund also may not be considered as an available resource. A pre-need funeral service contract, prepayment, or deposit designated under this section is not a multiple-party account for purposes of chapter 30.1-31. No claim for payment of funeral expenses may be made against the estate of a deceased medical assistance recipient except to the extent that funds maintained in accordance with this section total less than five thousand dollars.

50-24.1-02.4. Exempt income and resources. The department may not consider, as an available asset for purposes of determining eligibility for benefits under this chapter, income and resources set aside by a blind or disabled person as part of a plan to achieve self-support, if the plan has been approved by the social security administration.

50-24.1-02.5. Effect of purchase of insurance on disqualifying transfer.

1. An individual who secures and maintains insurance that covers the cost of substantially all necessary medical care, including necessary care in a nursing home and necessary care for an individual who qualifies for admission to a nursing home but receives care elsewhere, for at least thirty-six months after the date an asset is disposed of, may demonstrate that the asset was disposed of exclusively for a purpose other than to qualify for medical assistance by providing proof of that insurance.

2. If purchased after July 31, 2003, the insurance coverage under this section must include home health care coverage, assisted living coverage, basic care coverage, and skilled nursing facility coverage. The coverage required under this subsection must include a daily benefit equal to at least one and fifty-seven hundredths times the average daily cost of nursing care for the year in which the policy was issued and an aggregate benefit equal to at least one thousand ninety-five times that daily benefit.

50-24.1-02.6. Medical assistance benefits - Eligibility criteria.

1. The department shall provide medical assistance benefits to otherwise eligible persons who are:

   a. Medically needy persons who have countable income that does not exceed an amount determined under subsection 2; and

   b. Minors who have countable income that does not exceed an amount determined under subsection 3.

2. The department of human services shall establish an income level for medically needy persons at an amount, no less than required by federal law, that, consistent with the requirements of subsection 3, is the greatest income level achievable without exceeding legislative appropriations for that purpose.

3. The department of human services shall establish income levels for minors, based on the age of the minors, at amounts, no less than required by federal law, that provide an income level for all minors born before September 30, 1983, equal to one hundred percent of the federal poverty level in the month for which eligibility for medical assistance benefits is being determined and that do not exceed legislative appropriations for that purpose.

4. The department of human services shall provide medical assistance benefits to children and families coverage groups and pregnant women without consideration of assets.

50-24.1-02.7. Workers with disabilities coverage. The department of human services shall establish and implement a buy-in program to provide medical assistance to an individual who, except for substantial gainful activity, meets the definition of disabled under the supplemental security income program under title XVI of the federal Social Security Act, who is at least sixteen but less than sixty-five years of age, and who is gainfully employed. The program must:

1. Be made available to an individual with a disability who is a member of a family the net income of which is less than two hundred twenty-five percent of the most recently revised official poverty line published by the federal office of management and budget for the family;

2. Allow up to an additional ten thousand dollars in assets;

3. Require the payment of a premium that is based upon a sliding scale which may not be less than two and one-half percent nor more than seven and one-half percent of the individual's gross countable income;

4. Include a one-time program enrollment fee of one hundred dollars; and

5. Provide that the failure of an enrolled individual to pay premiums for three months may result in the termination of enrollment in the program.

50-24.1-02.8. Transfers involving annuities.

1. For purposes of this section, "annuity" means a policy, certificate, contract, or other arrangement between two or more parties whereby one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future. Except for purposes of subsections 3 and 5, the term does not mean an employee benefit that qualifies for favorable tax treatment under the Internal Revenue Code or a plan described in the Internal Revenue Code as a retirement plan under which contributions must end and withdrawals begin by age seventy and one-half.

2. The purchase of an annuity, an instrument purporting to be an annuity, or any other arrangement that meets the definition of annuity in subsection 1 is considered an uncompensated assignment or transfer of assets under section 50-24.1-02, resulting in a penalty under the applicable rules established by the department of human services unless the following criteria are met:

   a. The annuity is a single premium immediate annuity or an annuity in which a settlement option has been selected, is irrevocable, and cannot be assigned to another person.

   b. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business.

   c. The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest. Payments will be considered substantially equal if the total annual payment in any year varies by five percent or less from the payment in the previous year.

   d. The annuity will return the full principal and interest within the purchaser's life expectancy as determined by the life expectancy tables published by the centers for medicare and medicaid services.

   e. The monthly payments from the annuity, unless specifically ordered otherwise by a court of competent jurisdiction, do not exceed the maximum monthly

income amount allowed for a community spouse as determined under 42 U.S.C. 1396r-5.

3. Unless done in compliance with subsection 4, a provision in an annuity that purports to preclude assignment or transfer of any interest in the annuity is void as against public policy upon application of the purchaser, the purchaser's spouse, the annuitant, or the annuitant's spouse for benefits under this chapter. This subsection applies only to an annuity for which a payment option has been irrevocably selected after July 31, 2005.

4. An annuity, an instrument purporting to be an annuity, or any other arrangement that meets the definition of annuity in subsection 1, purchased after July 31, 2005, is not an available asset and the expenditure of funds to purchase such an annuity, instrument, or other arrangement may not be considered to be a disqualifying transfer of an asset for purposes of this chapter if:

   a. The annuity is purchased from an insurance company or other commercial company that sells annuities as part of the normal course of business;

   b. The annuity is irrevocable and neither the annuity nor payments due under the annuity may be assigned or transferred;

   c. The monthly payments from all annuities owned by the purchaser that comply with this subsection may not exceed the minimum monthly maintenance needs allowance for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5 and, when combined with the purchaser's other monthly income, at the time of application of the purchaser, the purchaser's spouse, the annuitant, or the annuitant's spouse, for benefits under this chapter, do not exceed one hundred fifty percent of the minimum monthly maintenance needs allowance allowed for a community spouse as determined by the department pursuant to 42 U.S.C. 1396r-5;

   d. The annuity provides substantially equal monthly payments of principal and interest and does not have a balloon or deferred payment of principal or interest. Payments will be considered substantially equal if the total annual payment in any year varies by five percent or less from the payment in the previous year;

   e. The annuity will return the full principal and has a guaranteed period that is equal to at least eighty-five percent of the purchaser's life expectancy as determined by the life expectancy tables used by the department of human services; and

   f. The annuity does not include any provision that limits the effect of subsection 5.

5. Except as provided in subsection 2, before benefits under this chapter may be provided to an otherwise eligible applicant who is fifty-five years of age or older, the department of human services, or the successor of that department, must be irrevocably named on each annuity owned by that applicant, or by the spouse of that applicant, that complies with subsection 4, as primary beneficiary for payment of amounts due following the death of the applicant and the applicant's spouse, if any, not to exceed the amount of benefits paid under this chapter on behalf of that applicant after age fifty-five, plus interest on that amount at the legal rate from six months after the applicant's death. If the department receives notice within ninety days of the death of the applicant or the applicant's spouse that reliably demonstrates that the applicant is survived by a minor child who resided and was supported financially by the deceased or by a permanently and totally disabled child, the department shall remit any payments made to the department under this section to those survivors in equal shares. When the obligations to the minor child or

children who resided and were supported financially by the deceased or the permanently and totally disabled child or children and the department are fulfilled, the department shall remit any future payments made to the department under this section to the contingent beneficiaries selected by the annuitant regarding each annuity owned by the applicant or by the spouse of the applicant which complies with subsection 4.

50-24.1-02.9. (Contingent effective date - See note) Effect of purchase of long-term care insurance on eligibility for medical assistance benefits.

1. Notwithstanding any other provision of law to the contrary, the assets of an individual must be disregarded when determining medical assistance eligibility if the individual owns a long-term care insurance policy as described in this section and purchased before application for medical assistance was made. For purposes of this section, assets mean any kind of property or property interest, whether real, personal, or mixed, whether liquid or illiquid, and whether presently vested with possessory rights and that would be considered in determining eligibility for medical assistance. The following asset disregards must be applied:

   a. A one dollar increase in the medical assistance asset limit must be granted to an individual who is the beneficiary of a long-term care insurance policy that meets the requirements of this section for each one dollar of benefit paid out under the individual's long-term care insurance policy for long-term care services; or

   b. The total assets an individual owns and may retain and still qualify for medical assistance benefits at the time the individual applies for benefits must be disregarded if the individual is the beneficiary of a long-term care insurance policy that meets the requirements of this section, provides maximum benefits at the time of purchase of at least the total asset protection amount in effect at the time of purchase, and includes a provision under which the daily benefit increases by at least five percent per year compounded at least annually, and that individual has exhausted the benefits of the long-term care insurance policy.

2. As used in this section, long-term care insurance has the meaning set forth in section 26.1-45-01.

3. As used in this section, "total asset protection amount" means a maximum benefit equal to one hundred sixty-four thousand two hundred fifty dollars for policies purchased during 2005 and that amount plus an additional five percent compounded annually for policies purchased in any year after 2005.

50-24.1-03. County share of medical assistance - Reimbursement for clinic services not required. Repealed by S.L. 1997, ch. 403, § 13.

50-24.1-03.1. Duties of county agency. In the administration of the medical assistance program, a county agency shall:

1. Administer the medical support enforcement program under the direction and supervision of the department of human services. In administering the program the county agency shall have the authority to contract with any public or private agency or person to discharge their medical support enforcement duties.

2. Make an investigation and record the circumstances of each applicant or recipient of assistance, in order to ascertain the facts supporting the application, or the granting of assistance, and shall obtain such other information as may be required by the rules and regulations of the department of human services.

50-24.1-03.2. Investigations - Power of county agencies, department, and employees. In the investigation of applications under the provisions of this chapter, the county agencies, the department of human services, and the officials and employees of such agencies charged with the administration and enforcement of this chapter may:

1. Conduct examinations.

2. Require the attendance of witnesses and the production of books, records, and papers.

3. Make application to the district court of the county to compel the attendance of witnesses and the production of books, records, and papers.

4. Request from state, county, and local agencies information deemed necessary to carry out the medical support enforcement program. All officers and employees of state, county, and local agencies shall cooperate with the department of human services and the county agency in locating absent spouses or parents of children to whom an obligation of support is owed or on whose behalf assistance is being provided and, on request, shall supply the department or the county agency with available information relative to the location, income, social security number, and property holdings of the absent spouse or parent, notwithstanding any provision of law making that information confidential. Any person acting under the authority of the department of human services who pursuant to this subsection obtains information from the office of the state tax commissioner, the confidentiality of which is protected by law, may not divulge such information except to the extent necessary for the administration of the medical support enforcement program or when otherwise directed by judicial order or when otherwise provided by law.

The officers and employees designated by the county agencies or the department of human services may administer oaths and affirmations.

50-24.1-04. Authority of department. The department of human services is authorized to promulgate such rules and regulations as are necessary to qualify for any federal funds available under this chapter.

50-24.1-05. Date effective. The effective date of this chapter is the date on which federal funds become available for the purposes and program outlined herein.

50-24.1-06. Remedial eye care - When provided. On the basis of the findings of an examination made by an ophthalmologist, optometrist, or physician skilled in the diseases of the eye, recommended remedial eye care services must be provided to any individual under the age of sixty-five who is in need of remedial eye care services if the individual is not blind as defined under title XVI of the Social Security Act [42 U.S.C. 1381 et seq.], and the individual is otherwise qualified for assistance under this chapter. Except for services furnished in a medical emergency, the department may not pay for recommended remedial eye care services unless the individual receiving those services first applies for and receives authorization from the department. As used in this section, "remedial eye care services" mean services to prevent blindness or to restore an individual's eyesight, but does not include treatment of diseases causing an impairment or a loss of eyesight, such as diabetes and high blood pressure, ordinary eye examinations, eye glasses, physical examinations, or travel and other expenses necessary to receive treatment.

50-24.1-07. Recovery from estate of medical assistance recipient.

1. On the death of any recipient of medical assistance who was fifty-five years of age or older when the recipient received the assistance, and on the death of the spouse of the deceased recipient, the total amount of medical assistance paid on behalf of the recipient following the recipient's fifty-fifth birthday must be allowed as a

preferred claim against the decedent's estate after payment, in the following order, of:

a. Funeral expenses not in excess of three thousand dollars;

b. Expenses of last illness;

c. Expenses of administering the estate, including attorney's fees approved by the court;

d. Claims made under chapter 50-01;

e. Claims made under chapter 50-24.5; and

f. Claims made under chapter 50-06.3 and on behalf of the state hospital.

2. A claim may not be required to be paid nor may interest begin to accrue during the lifetime of the decedent's surviving spouse, if any, nor while there is a surviving child who is under the age of twenty-one years or is blind or permanently and totally disabled, but no timely filed claim may be disallowed because of the provisions of this section.

3. Every personal representative, upon the granting of letters of administration or testamentary shall forward to the department of human services a copy of the petition or application commencing probate, heirship proceedings, or joint tenancy tax clearance proceedings in the respective district court, together with a list of the names of the legatees, devisees, surviving joint tenants, and heirs at law of the estate. Unless a properly filed claim of the department of human services is paid in full, the personal representative shall provide to the department a statement of assets and disbursements in the estate.

50-24.1-08. Statute of limitations does not run. The statute of limitations does not run against claims of the state of North Dakota for repayment of medical assistance provided under this chapter.

50-24.1-09. Reimbursement of long-term care facility - Limitation - Allowable costs. Repealed by S.L. 1987, ch. 582, § 30.

50-24.1-10. Joint medicaid payment account - Educationally related services. The state treasurer shall establish a joint medicaid payment account for the department of human services and the department of public instruction to pay for services provided handicapped children allowed under the Medicare Catastrophic Act of 1988. This account shall be for the receipt and payment of department of public instruction matching funds and department of human services federal medicaid funds for the purpose of making payments to the provider or providers of services as directed by the department of human services. The department of public instruction shall provide the department of human services such administrative services in the documentation and payment of these funds as the department of human services may request.

50-24.1-11. Joint medicaid payment account - North Dakota vision services - school for the blind. The state treasurer shall establish a joint medicaid payment account for the department of human services and the North Dakota vision services - school for the blind for purposes of providing services including alternative living arrangements for persons determined eligible for the receipt of residential and other services by the North Dakota vision services - school for the blind. This account shall be for the receipt and payment of North Dakota vision services - school for the blind matching funds and department of human services federal medicaid funds for the purpose of making payments to the provider or providers of service as directed by the department of human services. The North Dakota vision services - school for the blind shall provide the department of human services such administrative services in the documentation and payment of these funds as the department of human services may request.

50-24.1-12. Medical assistance - Services provided by psychologists. Within the limits of legislative appropriations, the department of human services shall provide medical assistance to eligible recipients for services provided by psychologists licensed under chapter 43-32.

50-24.1-13. Provider reimbursement rates. If sufficient general fund appropriations are available to increase provider reimbursement rates, the department shall review reimbursement rates paid to providers under this chapter and shall increase the reimbursement rates accordingly.

50-24.1-14. Responsibility for expenditures - Exceptions.

1. Except as otherwise specifically provided in subsection 2 and section 50-03-08, expenditures required under this chapter are the responsibility of the federal government or the state of North Dakota.

2. Each county shall reimburse the department of human services the amount required to be appropriated under subsection 3 of section 50-03-08.

50-24.1-15. Prehospital emergency medical services. Medical assistance coverage must include prehospital emergency medical services benefits in the case of a medical condition that manifests itself by symptoms of sufficient severity which may include severe pain and which a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the person's health in jeopardy, serious impairment of a bodily function, or serious dysfunction of any body part. A medical assistance claim that meets the prudent layperson standard of this section may not be denied by the department on the basis that the prehospital emergency medical services were not medically necessary or that a medical emergency did not exist.

50-24.1-16. Reimbursement of ambulance services. Medical assistance coverage must include reimbursement of ambulance services for responding to calls to assist covered individuals which do not result in transport. The reimbursement must be at a rate negotiated by the department and the ambulance service.

50-24.1-17. Medical assistance for breast or cervical cancer. The department of human services may provide medical assistance for women screened and found to have breast or cervical cancer in accordance with the federal Breast and Cervical Cancer Prevention and Treatment Act of 2000 [Pub. L. 106-354; 114 Stat. 1381; 42 U.S.C. 1396a et seq.]. The department shall establish an income eligibility limit that may not exceed two hundred percent of the poverty line for payments made under this section. For purposes of this section, poverty line means the official income poverty line as defined by the United States office of management and budget and revised annually in accordance with 42 U.S.C. 9902(2), applicable to a family of the size involved.

50-24.1-18. Personal care option - Basic care facilities. The department of human services may implement a personal care option benefit program. Personal care option benefits may only be made available to qualifying individuals who reside in basic care facilities. As used in this section, "basic care facility" has the meaning provided in section 23-09.3-01.

50-24.1-18.1. Personal care services - Residing at home. Subject to the requirements under title 42, Code of Federal Regulations, part 440, section 167, the department of human services shall provide personal care services for eligible medical assistance recipients who are residing in their own homes. The department shall seek a waiver of federal law to permit disabled and elderly individuals to direct their own care and to permit personal care services authorized under this section to be provided by nonlicensed personal care service providers.

50-24.1-19. Oral maxillofacial services - Medical necessity. The department of human services shall make oral maxillofacial surgical services and orthodontic services in conjunction with, or in lieu of, such surgical services available through the medicaid program to

anyone who is a medicaid recipient if such services are reasonably likely to correct or mitigate a congenital or acquired deformity associated with a significant functional impairment in drinking, eating, swallowing, or speaking.

50-24.1-20. Home and community-based living - Choice of options. Any aged or disabled individual who is eligible for home and community-based living must be allowed to choose, from among all service options available, the type of service that best meets that individual's needs. To the extent permitted by any applicable waiver, the individual's medical assistance funds must follow the individual for whichever service option the individual selects, not to exceed the cost of the service. The department of human services shall apply for the waivers and grants necessary to implement this section under existing or future federal legislation.

50-24.1-21. Department to submit plans and seek waivers.

1. Unless a waiver under subsection 2 is required, the department of human services shall submit amendments to the state plan for medical assistance to provide for a sixty-month look-back period for assignments or transfers of property which disqualify the applicant or the applicant's spouse from the receipt of long-term care services.

2. If the state plan amendment provided for in subsection 1 is or will be denied, the department of human services shall seek a waiver of federal law to provide for a sixty-month look-back period for assignments or transfers of property which disqualify the applicant or the applicant's spouse from the receipt of long-term care services.

3. Unless the amendment to the state plan or the request for waiver would otherwise be denied, the requirements of this section apply only to transfers that occur on or after the effective date of the state plan amendment or waiver.

50-24.1-22. Long-term care facility information. A long-term care facility may request that an applicant for admission, a resident of the facility, or the applicant's or resident's legal representative furnish financial information regarding income and assets, including information regarding any transfers or assignments of income or assets. A long-term care facility may deny admission to an applicant for admission who is unable to verify a viable payment source.

50-24.1-23. Long-term care facility resident - Medical assistance eligibility. An individual is not ineligible for medical assistance if application of disqualifying transfer provisions would deprive the individual of nursing care and services and the individual makes a satisfactory showing that:

1. For periods after the return, all income or assets constituting the disqualifying transfer have been transferred or assigned back to the individual and the individual is otherwise eligible for medical assistance; or

2. Compensation equal to the fair market value of the income or asset at time of transfer is paid to, or on behalf of, the individual for nursing care and services provided by a long-term care facility and the individual is otherwise eligible for medical assistance.

50-24.1-24. Provider appeals - Definitions.

1. For purposes of this section:

   a. "Denial of payment" means that the department has denied payment for a medical assistance claim or reduced the level of service payment for a service provided to an individual who was an eligible medical assistance recipient at the time the service was provided.

b. "Department" means the department of human services.

c. "Provider" means an individual, entity, or facility that furnishes medical or remedial services or supplies pursuant to a provider agreement with the department.

2. A provider may request a review of denial of payment under this section by filing within thirty days of the date of the department's denial of the claim a written notice with the department which includes a statement of each disputed item and the reason or basis for the dispute. A provider may not request review under this section of the rate paid for a particular service.

3. Within thirty days after requesting a review, a provider shall provide to the department all documents, written statements, exhibits, and other written information that support the provider's request for review, together with a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item.

4. The department shall assign to a provider's request for review someone other than any individual who was involved in the initial denial of the claim. A provider who has requested review may contact the department for an informal conference regarding the review anytime before the department has issued its final decision.

5. The department shall make and issue its final decision within seventy-five days of receipt of the notice of request for review. The department's final decision must conform to the requirements of section 28-32-39. A provider may appeal the final decision of the department to the district court in the manner provided in section 28-32-42, and the district court shall review the department's final decision in the manner provided in section 28-32-46. The judgment of the district court in an appeal from a request for review may be reviewed in the supreme court on appeal by any party in the same manner as provided in section 28-32-49.

6. Upon receipt of notice that the provider has appealed its final decision to the district court, the department shall make a record of all documents, written statements, exhibits and other written information submitted by the provider or the department in connection with the request for review and the department's final decision on review, which constitutes the entire record. Within thirty days after an appeal has been taken to district court as provided in this section, the department shall prepare and file in the office of the clerk of the district court in which the appeal is pending the original and a certified copy of the entire record, and that record must be treated as the record on appeal for purposes of section 28-32-44.

50-24.1-25. Operating costs for developmental disabilities service providers. The department of human services shall determine annual payment rates for private, licensed developmental disability providers by applying the inflation rate for these providers used to develop the legislative appropriation for the department.

50-24.1-26. Medicaid waiver - In-home services. The department shall apply for a medicaid waiver to provide in-home services to children with extraordinary medical needs who would otherwise require hospitalization or nursing facility care. The department may limit the waiver to fifteen participants and may prioritize applicants by degree of need.

50-24.1-27. Medical assistance program management. The department of human services, with respect to the state medical assistance program, shall:

1. Provide statewide targeted case management services to include a concentrated, but not an exclusive, emphasis for the two thousand medical assistance recipients with the highest cost for treatment of chronic diseases and the families of neonates that can benefit from case management services. Case management services must

focus on those recipients in these groups which will result in the most cost-savings, taking into consideration available resources, and may include a primary pharmacy component for the management of medical assistance recipient medication.

2. Require medical assistance providers to use the appropriate diagnosis or reason and procedure codes when submitting claims for medical assistance reimbursement; review and develop recommendations to identify instances in which a provider of services is not properly reporting diagnosis or reason and procedure codes when submitting claims for medical assistance reimbursements; and review and recommend any specific providers from which a potential benefit might be obtained by requiring additional diagnosis or reason and procedure codes.

3. Review and develop recommendations for the improvement of mental health treatment and services including the use of prescription drugs for medical assistance recipients.

4. Review and develop recommendations regarding whether the number of medical assistance recipients who are placed in out-of-state nursing homes should be reduced.

5. Review and develop recommendations regarding whether the use of post-office addresses or street addresses are the appropriate mailing addresses for medical assistance recipients.

6. Review and develop recommendations regarding whether to require medical assistance providers to secure prior authorization for certain high-cost medical procedures.

7. Review and develop recommendations regarding whether a system for providing and requiring the use of photo identification medical assistance cards for all medical assistance recipients should be implemented.

8. Review and develop recommendations regarding whether medical assistance providers should be required to use tamper-resistant prescription pads.

9. Develop a plan to provide information to blind and disabled medical assistance recipients who may be eligible for part D benefits under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1]. The information must inform recipients of part D benefits for which the recipient may be eligible.

10. Review and recommend a plan for implementing the necessary infrastructure to permit risk-sharing arrangements between the department and medical assistance providers.

50-24.1-28. Medical assistance and medicare prescription drug management program. The department of human services, with respect to the state medical assistance program, shall develop a plan for the implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1]. The department may purchase the services of an outside consultant to assist in the development of the plan. The requirements of chapter 54-44.4 do not apply to the purchase of the consultant services. The department may not pay for:

1. A prescription drug that is within a class of drugs covered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1] and which is prescribed to a medical assistance recipient who is also a medicare beneficiary.

2. A prescription drug that is not covered and for which no drug in its class is covered under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1] and which is prescribed for an individual who is a medical assistance recipient and a medicare beneficiary unless federal medical assistance matching funds are available at no less than the federal medical assistance percentage and the department determines that the drug is medically necessary for the individual.

3. A prescription drug for which federal medical assistance matching funds are not available except that until February 15, 2006, the department may pay for the drug in an emergency to ensure that a medical assistance recipient who is also a medicare beneficiary may continue to receive appropriate medications after implementation of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 [Pub. L. 108-173; 117 Stat. 2066; 42 U.S.C. 1396kk-1].